

Ministry of Health and Long-Term Care

Patient Enrolment and Consent to Release Personal Health Information

One form per adult patient. Photocopy for additional adult family members.

Collection of the information on this form is under the authority of the *Ministry of Health Act*, subsection 6(1) and (2) and the *Health Insurance Act*, R.S.O. 1990, c. H.6, s.4(2)(b) and (f), 4.1(1) and (2), 10 and 11(1). For information about collection practices, contact the Director, Registration and Claims Branch, Box 48, 49 Place d'Armes, Kingston ON K7L 5J3, INFOline tel. 1 888 218-9929 or by mail through the addresses listed for local Ministry of Health and Long-Term Care offices.

Microfilm use only

Section 1 I want to enrol myself with the family doctor identified in Section 4						
Last Name		First Name			Second Name	
Health Number	Version		Apartment #	Street No. and Name or	l · P.O. Box. Bural F	Route, General Delivery
	Code	Mailing Address ▶				,
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Date of Birth (yyyy/mm/dd)			City/Town			Postal Code
	M DF					
Send notices from my family doctor's office to me by:		Residence	Apartment # Street No. and Name or Lot, Concession and Township			
regular mail email (if possible)		Address >				
Email Address:		or same as	City/Town			Postal Code
		mailing				
Section 2 I want to enrol my child	ren) under	address 16 and/or de	nendent ac	lult(s) with the fam	ily doctor ider	ntified in Section 4
Last Name	icii) anaci	First Name	-	idit(5) With the fam	Second Name	ranica in occasion 4
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Health Number	Code	Mailing Address ▶	Apartment #	Street No. and Name of	r P.O. Box, Rurai F	Route, General Delivery
Date of Birth (yyyy/mm/dd)		or same as	City/Town			Postal Code
	M \square F	Section 1				
I am this person's		Residence	Apartment #	Street No. and Name of	r Lot, Concession	and Township
parent		Address >				
legal guardian		or	City/Town			Postal Code
attorney for personal care		same as				
Last Name		Section 1	First Name Second Name			
B	Filst Nami	e Gecord Name				
Health Number	Version I Code	Mailing Address ▶	Apartment #	Street No. and Name of	P.O. Box, Rural F	Route, General Delivery
		Addiess				
Date of Birth (yyyy/mm/dd) Se	x	or same as	City/Town			Postal Code
_ , , , , , □	M \square F	Section 1				
I am this person's		Residence	Apartment # Street No. and Name or Lot, Concession and Township		and Township	
parent		Address >				
legal guardian		or	City/Town			Postal Code
attorney for personal care		same as				
		☐ Section 1				
Section 3 Signature			Section 4	Family doctor in	ormation	
I have read and agree to the Patient Commitment, the Consent to Release Personal Health Information and the Cancellation Conditions on the back of						
this form. I acknowledge that this Enrolment is not intended to be a legally binding contract and is not intended to give rise to any new legal obligations						
between my family doctor and me.						
I am signing on behalf of (check all that apply)						
myself child(ren) dependent adult(s)						
My Name						
last name first name						
	In					
Signature Date (yyyy/n		nm/dd)				
X						
Home Telephone No. Work Telephone No.			Family Doctor's Signature		Date (yyyy/mm/dd)	
()			x			